DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 0 2

2. STATE: Wisconsin

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
01/01/01

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
SSA Section 1905(a)(2)(B)

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 0
b. FFY 2002 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B pp. 6a & 10 .....

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
Prospective payment system for Federally Qualified Health Clinics and Rural Health Clinics

11. GOVERNOR'S REVIEW *(Check One)*:

☑ GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ OTHER, AS SPECIFIED:
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Peggy L. Bartels

13. TYPED NAME:
Peggy L. Bartels

14. TITLE:
Administrator, Division of Health Care Financing

15. DATE SUBMITTED:
March 30, 2001

16. RETURN TO:
Peggy L. Bartels
Administrator
Division of Health Care Financing
P.O. Box 309
Madison, WI 53701-0309

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
03/30/01

18. DATE APPROVED: 1/4/02

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:
Cheryl A. Harris

21. TYPED NAME:
Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

6. Rural Health Clinics

Claims for Rural Health Clinic (RHC) services are reimbursed by Wisconsin Medicaid on a fee-for-service basis at the lower of:

- The provider's usual and customary fee; or
- Medicaid's maximum allowable fee.

In addition to fee-for-service reimbursement, all RHCs, other than such clinics in rural hospitals with less than 50 beds, that complete a cost report are eligible to receive interim payments with final settlements based on 100% of reasonable costs, up to a maximum limit as established or allowed in HCFA publication 27, RHC and FQHC Manual, Chapter 505.1.

RHCs in rural hospitals with less than 50 beds that complete a cost report are eligible to receive interim payments with final settlements based on 100% of reasonable costs as determined according to Medicare cost reimbursement principles. This provision is effective for final settlements completed on or after October 1, 1998, for services provided on or after January 1, 1998.

RHC reasonable cost payments are made on a per encounter basis by ascertaining the average cost per day, per provider, per recipient at the RHC. An encounter is defined as a face-to-face encounter between a recipient and any Medicaid physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist or clinical social worker.

Effective 7-1-96

Prospective Payment System for Federally Qualified Health Centers and Rural Health Clinics

Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) repeals the reasonable cost-based reimbursement provisions of the Social Security Act and replaces them with a prospective payment system (PPS) for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). States have the option to pay clinics under an alternative methodology, if the alternative methodology does not pay less than what would be paid under the PPS.

Wisconsin uses a cost-settlement system to reimburse clinics at 100% of reasonable costs. The Department will maintain this system under BIPA as an alternative methodology for payment. Furthermore, the Department will continue to reimburse RHCs their reasonable costs using the cost-settlement system while the Department implements BIPA's provisions. The Department will, if necessary, make retroactive adjustments to settlement amounts paid to clinics back to January 1, 2001. Wisconsin's RHCs have agreed to this alternative payment methodology.

6. Rural Health Clinics (cont.)

Cost-Settlement Process – Fee for Service

RHCs bill fee-for-service (FFS) Medicaid for Medicaid services rendered to Medicaid patients. The RHCs then submit cost reports to the Department which indicate the number of Medicaid encounters and the amount already reimbursed by FFS Medicaid. The Department reimburses RHCs the difference between what has been received from FFS Medicaid and their reasonable costs.

Clinics receive settlement payments at least every four months. Annual audits of clinics may show that these clinics received excess payments throughout the year, which must be refunded to the Department.

Cost-Settlement Process – Managed Care

RHCs receive payments from a Medicaid-contracted managed care organization (MCO) for Medicaid services rendered to Medicaid patients. The RHCs then submit cost reports to the Department which indicate the number of Medicaid encounters and the amount already reimbursed by Medicaid-contracted MCOs. The Department reimburses RHCs the difference between what has been received from Medicaid MCOs and their reasonable costs.

Clinics receive settlement payments at least every four months. Annual audits of clinics may show that these clinics received excess payments throughout the year, which must be refunded to the Department.

6. Rural Health Clinics (cont.)

Methodology for Calculating a Baseline PPS Rate

The Division of Health Care Financing (DHCF) will calculate a baseline PPS rate using the following methodology:

1) Annual cost reports for an RHC's fiscal years 1999 and 2000 are submitted to the DHCF by the clinics.

2) The DHCF audits the submitted cost reports thereby establishing an annual encounter rate for each clinic for clinic fiscal years 1999 and 2000.

3) The PPS baseline rate is calculated by weighting the audited encounter rates for FY 1999 and FY 2000 based on the share of audited Medicaid RHC encounters during the respective fiscal years:

A) The numbers of audited Medicaid RHC encounters for FY 1999 and FY 2000 are determined and then added together to obtain the total number Medicaid encounters at the clinic in both fiscal years. The share of total encounters that occurred in each fiscal year is then calculated.

B) The share of total encounters that occurred in each fiscal year is then multiplied by that fiscal year's encounter rate to obtain an apportioned encounter rate for each fiscal year.

C) The apportioned encounter rates for FY 1999 and FY 2000 are totaled to yield the PPS baseline rate.

The Department will compare the PPS rate calculated for each clinic to the encounter rate paid under the cost settlement methodology and will pay the clinic the higher of the two. For clinics for which the PPS rate is the higher of the two, the Department will use the PPS rate as the encounter rate when determining a clinic's interim and annual settlement payments using the cost settlement methodology described above.

For clinics that have not submitted FY 1999 and FY 2000 cost report data, the Department will request in writing that the clinic provide this data to the Department so that it can calculate a baseline PPS rate. In the interim, the Department will continue to pay clinics using the cost-settlement process. If a clinic has not submitted FY 1999 and FY 2000 cost report data to the Department one year after the Department has requested in writing from the clinic such data, the Department will use the PPS rate from a clinic in the same or adjacent area with a similar caseload as the baseline PPS rate for the clinic that has not submitted FY 1999 and FY 2000 cost report data requested by the Department.

6. Rural Health Clinics (cont.)

Subsequent Years (FY 2002 and beyond)

At the end of each clinic fiscal year, the Department will adjust the PPS rate by the Medicare Economic Index (MEI) in effect at the end of the clinic fiscal year and by expected changes in the scope of services provided to Medicaid patients at the clinic to determine the PPS rate for that clinic upcoming fiscal year. Clinics will be required to report to the Department expected staffing and service provision changes for the upcoming clinic fiscal year no later than one month prior to the end of the current clinic fiscal year. Staffing changes are to be estimated as changes in the number of full time equivalents (FTEs) employed by or contracting with the clinic to provide RHC services and their estimated costs. Clinics must also submit written documentation to the Department of the estimated costs of relevant capital changes that would affect the provision of RHC services at the clinic. Changes to the PPS rate based on expected staffing or service provision changes as reported by the clinic that do not occur in the upcoming clinic fiscal year are subject to reconciliation at the end of the clinic's fiscal year.

The adjusted PPS rate will be compared to the settlement rate for that clinic fiscal year, and the Department will pay the clinic the greater of the two. For clinics for which the PPS rate is the higher of the two, the Department will use the PPS rate as the encounter rate when determining a clinic's interim and annual settlement payments using the cost settlement methodology described above.

New Clinics

For clinics that qualify for RHC status after FY 2000, the Department will use the PPS rate from a clinic in the same or adjacent area with a similar caseload. This rate will be compared to the rate paid by the settlement process, and the Department will pay the higher of the two. In subsequent years, the Department will inflate the PPS rate by the MEI and by changes in the scope of services provided and will compare this rate to that from the settlement process. The Department will pay the clinic the greater of the two. In the absence of a clinic in the same or adjacent area with a similar caseload, the cost settlement rate will be paid to the clinic.

6. Rural Health Clinics (cont.)

Supplemental Payments under Managed Care

RHCs that provide services under a contract with a Medicaid managed care organization (MCO) will receive state supplemental payments for the cost of furnishing such services. These supplemental payments are an estimate of the difference between the payments the RHC receives from MCO(s) and the payments the RHC would have received under the alternative methodology. At the end of each RHC fiscal year, the total amount of supplemental and MCO payments received by the RHC will be reviewed against the amount that the actual number of visits provided under the RHC's contract with MCO(s) would have yielded under the alternative methodology. The RHC will be paid the difference between the amount calculated using the alternative methodology and actual number of visits, and the total amount of supplemental and MCO payments received by the RHC, if the alternative amount exceeds the total amount of supplemental and MCO payments. The RHC will refund the difference between the alternative amount calculated using the actual number of visits, and the total amount of supplemental and MCO payments received by the RHC, if the alternative amount is less than the total amount of supplemental and MCO payments.

Effective 1-1-01

HPSA incentive payments encourage primary care physicians and mid level health professionals to provide primary care services to Medical Assistance recipients who live in medically underserved areas of Wisconsin. The HPSA Incentive program is an adaptation of the Medicare HPSA program, with a special emphasis on primary care services. The enhanced payment assists HPSA areas in recruitment and retention of physicians and midlevel health professionals.

The reasons for targeting primary care services are discussed in the Primary Care Provider Incentive Payment (number 22 below).

Effective for payments made on or after 10-16-93 for dates of service on and after July 1, 1993

16. Federally Qualified Health Centers (FQHCs)

FQHC reasonable cost payments are made on a per encounter basis by ascertaining the average cost per day, per provider, per recipient at the FQHC. An encounter is defined as a face-to-face contact for the provision of medical services between a single Wisconsin Medical Assistance Program (WMAP) certified provider (e.g., physician, dentist, or physical therapist) on a single day, at a single location, for a single diagnosis or treatment. When a recipient receives care from multiple WMAP-certified providers in a day, multiple encounters are recorded.

Effective 7-1-92

Prospective Payment System for Federally Qualified Health Centers and Rural Health Clinics

Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) repeals the reasonable cost-based reimbursement provisions of the Social Security Act and replaces them with a prospective payment system (PPS) for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). States have the option to pay clinics under an alternative methodology, if the alternative methodology does not pay less than what would be paid under the PPS.

Wisconsin uses a cost-settlement system to reimburse clinics at 100% of reasonable costs. The Department will maintain this system under BIPA as an alternative methodology for payment. Furthermore, the Department will continue to reimburse FQHCs their reasonable costs using the cost-settlement system while the Department implements BIPA's provisions. The Department will, if necessary, make retroactive adjustments to settlement amounts paid to clinics or centers back to January 1, 2001. Wisconsin's FQHCs have agreed to this alternative payment methodology.

16. Federally Qualified Health Centers (FQHCs) (cont.)

Cost-Settlement Process – Fee for Service

FQHCs bill fee-for-service (FFS) Medicaid for Medicaid services rendered to Medicaid patients. The FQHCs then submit cost reports to the Department which indicate the number of Medicaid encounters and the amount already reimbursed by FFS Medicaid. The Department reimburses FQHCs the difference between what has been received from FFS Medicaid and their reasonable costs.

Centers receive settlement payments at least every four months. Annual audits of centers may show that these centers received excess payments throughout the year, which must be refunded to the Department.

Cost-Settlement Process – Managed Care

FQHCs receive payments from a Medicaid-contracted managed care organization (MCO) for Medicaid services rendered to Medicaid patients. The FQHCs then submit cost reports to the Department which indicate the number of Medicaid encounters and the amount already reimbursed by Medicaid-contracted MCOs. The Department reimburses FQHCs the difference between what has been received from Medicaid MCOs and their reasonable costs.

Centers receive settlement payments at least every four months. Annual audits of centers may show that these centers received excess payments throughout the year, which must be refunded to the Department.

16. Federally Qualified Health Centers (FQHCs) (cont.)

Methodology for Calculating a Baseline PPS Rate

The Division of Health Care Financing (DHCF) will calculate a baseline PPS rate using the following methodology:

1) Annual cost reports for an FQHC's fiscal years 1999 and 2000 are submitted to the DHCF by the centers.

2) The DHCF audits the submitted cost reports thereby establishing an annual encounter rate for each center for center fiscal years 1999 and 2000.

3) The PPS baseline rate is calculated by weighting the audited encounter rates for FY 1999 and FY 2000 based on the share of audited Medicaid FQHC encounters during the respective fiscal years:

A) The numbers of audited Medicaid FQHC encounters for FY 1999 and FY 2000 are determined and then added together to obtain the total number Medicaid encounters at the center in both fiscal years. The share of total encounters that occurred in each fiscal year is then calculated.

B) The share of total encounters that occurred in each fiscal year is then multiplied by that fiscal year's encounter rate to obtain an apportioned encounter rate for each fiscal year.

C) The apportioned encounter rates for FY 1999 and FY 2000 are totaled to yield the PPS baseline rate.

The Department will compare the PPS rate calculated for each center to the encounter rate paid under the cost settlement methodology and will pay the center the higher of the two. For centers for which the PPS rate is the higher of the two, the Department will use the PPS rate as the encounter rate when determining a center's interim and annual settlement payments using the cost settlement methodology described above.

For centers that have not submitted FY 1999 and FY 2000 cost report data, the Department will request in writing that the center provide this data to the Department so that it can calculate a baseline PPS rate. In the interim, the Department will continue to pay centers using the cost-settlement process. If a center has not submitted FY 1999 and FY 2000 cost report data to the Department one year after the Department has requested in writing from the center such data, the Department will use the PPS rate from a center in the same or adjacent area with a similar caseload as the baseline PPS rate for the center that has not submitted FY 1999 and FY 2000 cost report data requested by the Department.

16. Federally Qualified Health Centers (FQHCs) (cont.)

Subsequent Years (FY 2002 and beyond)

At the end of each center fiscal year, the Department will adjust the PPS rate by the Medicare Economic Index (MEI) in effect at the end of the center fiscal year and by expected changes in the scope of services provided to Medicaid patients at the center to determine the PPS rate for that center upcoming fiscal year.

Centers will be required to report to the Department expected staffing and service provision changes for the upcoming center fiscal year no later than one month prior to the end of the current center fiscal year. Staffing changes are to be estimated as changes in the number of full time equivalents (FTEs) employed by or contracting with the center to provide FQHC services and their estimated costs. Centers must also submit written documentation to the Department of the estimated costs of relevant capital changes that would affect the provision of FQHC services at the center. Changes to the PPS rate based on expected staffing or service provision changes as reported by the center that do not occur in the upcoming center fiscal year are subject to reconciliation at the end of the center's fiscal year.

The adjusted PPS rate will be compared to the settlement rate for that center fiscal year, and the Department will pay the center the greater of the two. For centers for which the PPS rate is the higher of the two, the Department will use the PPS rate as the encounter rate when determining a center's interim and annual settlement payments using the cost settlement methodology described above.

New Clinics

For clinics that qualify for FQHC status after FY 2000, the Department will use the PPS rate from a center in the same or adjacent area with a similar caseload. This rate will be compared to the rate paid by the settlement process, and the Department will pay the higher of the two. In subsequent years, the Department will inflate the PPS rate by the MEI and by changes in the scope of services provided and will compare this rate to that from the settlement process. The Department will pay the center the greater of the two. In the absence of a center in the same or adjacent area with a similar caseload, the cost settlement rate will be paid to the center.

16. Federally Qualified Health Centers (FQHCs) (cont.)

Supplemental Payments under Managed Care

FQHCs that provide services under a contract with a Medicaid managed care organization (MCO) will receive state supplemental payments for the cost of furnishing such services at least every 4 months. These supplemental payments are an estimate of the difference between the payments the FQHC receives from MCO(s) and the payments the FQHC would have received under the alternate methodology. At the end of each FQHC fiscal year, the total amount of supplemental and MCO payments received by the FQHC will be reviewed against the amount that the actual number of visits provided under the FQHC's contract with MCO(s) would have yielded under the alternative methodology. The FQHC will be paid the difference between the amount calculated using the alternative methodology and actual number of visits, and the total amount of supplemental and MCO payments received by the FQHC, if the alternative amount exceeds the total amount of supplemental and MCO payments. The FQHC will refund the difference between the alternative amount calculated using the actual number of visits, and the total amount of supplemental and MCO payments received by the FQHC, if the alternative amount is less than the total amount of supplemental and MCO payments.

Effective 01/01/01